Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH CARE PLLC
2821 LACKLAND RD SUITE 300
FORT WORTH TX 76116

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-1945-01

MFDR Date Received
FEBRUARY 7, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Claim originally processed on 12/06/11 and paid $710.00 towards Procedure code J7799KD. A 1st Level Appeal was submitted on 12/23/11 with a cop of the invoice for the medications. The doctor had to pay $1155.00 for the medication and Insurance only paid $710.00. This does not even cover the cost of the medication. The Appeal was denied on 01/12/12 stating Original decision still stands, claim processed correctly."

Amount in Dispute: $445.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor refilled a pain pump with the following medication on 10/10/11: Baclofen 20mg, Bupivacaine 600 mg, Clonidine 10mg, Hydromorphone 400 mg, and Sufentanil 40 mg. The requestor alleges it cost him $1,155.00 to obtain the compounded medication and substantiates this with an 'invoice' showing $1,155.00… Medicare's Compounded Drug Fee Schedule for these medicals pays Baclofen 20mg, $125; Bupivacaine 600mg, $20; Clonidine 10mg, $88; Hydromorphone 400 mg, $110; and Sufentanil 40 mg, $425. This totals $768.00 then multiplied by the paf of 125% = $960.00. Texas Mutual paid $710. Thus it appears, in the absence of any clarifying information from the requestor, that the cost to him was $744.00. It also appears the request is due an additional payment of $192.00, which will be paid under separate cover… No further payment is due beyond the additional $192.00."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2011	HCPCS Code J7799KD	$445.00	$130.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the guidelines for medical services, charges, and payments for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the reimbursement methodology for pharmaceutical benefits.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W10 – Workers Compensation State Fee Schedule adjustment.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed correctly.
   - 724 – No additional payment after a reconsideration of services.

Issues

1. Was the requestor underpaid for the compound drugs?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.502 the Medicare Compounded Drug Fee Schedule allows, up to and including, $125.00 for Baclofen, 20mg; $20.00 for Bupivacaine, 600 mg; $88.00 for Clonidine, 10mg; $110.00 for Hydromorphone, 400mg; and $425.00 for Sufentanil, 40mg for a total of $768.00. The total amount is multiplied by 125% which totals $960.00. In accordance with 28 Texas Administrative Code §134.503(a)(2)(C) a compounding fee of $15 per compound shall be added for compound drugs. Total amount per the Medicare Drug Fee Schedule is $768.00 x 125% = $960.00 + $75.00 compounding fee = $1,035.00 - $902.00 (carrier payment) = $130.00

2. Review of the submitted documentation finds that the services were rendered as billed; therefore, additional reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $130.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $130.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 26, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.